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REPORT OF THE COMMITTEE APPOINTED BY THE MICHIGAN STATE MEDICAL SOCIETY TO SURVEY AND STUDY THE PROBLEM OF HOSPITAL CHARITY IN MICHIGAN HOSPITALS

PART 1. COMMUNITY HOSPITALS
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INTRODUCTION

At the one hundred and seventh annual meeting of the Michigan State Medical Society, held on Mackinac Island in June, 1927, your Committee submitted a preliminary report dealing with the problem of hospital charities in Michigan hospitals. That report was published in a supplement to The Journal of the Michigan State Medical Society in July, 1927, and may well be referred to in connection with the present one. It was divided into two parts, the first dealing with community hospitals, the second with the University Hospital. In the first part, the Committee made certain general recommendations. In the second, the Committee presented the results of its study up to that time, but purposely refrained from making any recommendations whatsoever. The object of the present report is to complete the recommendations made in the first part and to give the results of further study and to make certain definite recommendations in the latter.

PART I

COMMUNITY HOSPITALS

In its report last year, your Committee gave a considerable amount of data dealing with the community hospitals of the state, and enunciated certain principles which seemed to it to be sound, looking to the protection of the pocketbook of all hospitalized patients and such as involved the admission of those receiving charity. This necessarily involved, to some extent, the whole question of hospital financing. We have devoted some little time this year to the same questions. We have been impressed with the tremendous amount of time and effort which is being given to these medical-social-economic subjects by large hospitals, and the space in popular and special literature which is being allotted to them. They are problems to which there are at present but few definite answers. We are apparently in a period of intense experimentation, of exchanging views and of expressing opinions, and yet they press for solution. Progress, however, has been great and gratifying. We mention all this for fear that too much may be expected of your Committee, that after all are obliged to rely upon their personal experience in hospitals and their knowledge of the financial difficulties of their patients that have received institutional care.

We may be sure of one thing—namely, that our hospitals are making a righteous endeavor to solve the problems in a way fair to all concerned, including the doctor. We have learned to have greater sympathy for the social worker connected with such organizations. She is not the person of infinite sympathy for the indigent patient and one who is always striving to obtain our services without cost for those who might pay, as she is sometimes pictured. She makes mistakes, yes, but who of us has not done the same in his private work? Their methods of investigation are far more painstaking and exact, and lead,

we believe, in the main, to more just decisions than ours as to the ability of a patient to pay. We would bespeak a greater confidence in her and a greater co-operation between her and the doctor than are now in vogue.

Our last year's report contained much that, for the sake of brevity, we shall not repeat here. Some reiteration, however, is necessary.

HOSPITAL FINANCING

1. The original cost of buildings and of additions and other capital expenditures should be provided for from outside sources.

2. The articles of incorporation should be such as to free the institution from all taxes. This is the contribution of the tax paying public and stamps it as a purely philanthropic enterprise, devoted primarily to the care of the sick and disabled that come to its doors. This purpose should be kept ever in the foreground.

3. Governing bodies should endeavor to see that the business affairs of the hospital are conducted in an expert manner, looking always to the present needs and future development. In our Michigan hospitals and under ordinary circumstances, the "bad debts" item should be kept within five per cent. We believe this can be done without harshness to patients.

4. All unnecessary financial burden should be removed from the patient's shoulders. He may justly bear the cost of materials, such as food, linen, drugs, surgical supplies, etc., administration, housekeeping, laundry, common labor, heat, power and light, social service, laboratories, operating rooms, building maintenance, and other items from which he receives direct benefit.

5. The cost of a training school for nurses is a heavy one and the special nurse one of the major expenses of hospital illness. Patients now bear practically all of the costs of the training school. A part of this burden, at least, should fall upon other shoulders. The school should seek to furnish adequate nursing and to relieve patients as far as possible from the burden of the "special". A charge which represents the value of the nursing which he receives should be included in the expenses to be met by the patient.

6. The cost of internes' maintenance seems a proper one for the patient to bear, but any extraordinary educational expense may well be placed elsewhere.

7. The cost of research and educational advantages for the staff should, if possible, be met from other sources than that of the patient.

8. Minor new equipment, replacements, repairs, obsolescence would all seem to be properly borne by the patient.

9. Although the habit is less glaring than formerly, many miscellaneous expense items are now improperly allocated. Sensitiveness to the patient's pocketbook might well be even keener than at present.

10. Out-patient department costs, if carried at less than maintenance, should not be a general hospital burden to be borne by patients occupying the hospital.

We believe it a sound principle in hospital economics that the patient pay the cost of the particular accommodations that he occupies (as near as can be calculated) and his extras, and that those in better accommodations should not pay any part of the way of those in simpler ones. Those now carried at a less than cost figure should be provided for from outside sources, and that in case of corporations and other employers of labor under the compensation law, organized charity, social bodies doing welfare work, and city and county charges, the cost price should be charged, and not present ward rates, which are less than cost.

CHARITY WORK

The charity work of a community hospital is one of the most knotty questions connected with such institutions. We have already called attention to the vast amount of work which is being done to put it upon a more rational and discriminating basis. Accustomed as we are to working out our own problems in medicine and surgery on the basis of knowledge obtained by investigation, the method must appeal to us as being eminently sound. If we appreciate the difficulties with which hospitals have to contend, we will not be unappreciative of the tremendous efforts that are being made in this direction. At the same time, we must recognize that the matter has not been taken up with equal seriousness in all of our community hospitals; that the methods now in vogue are in process of development and contain imperfections, and that there is even a human element in carrying out the program. At the present time, we must emphasize again what we said last year—namely, that in the last analysis the judgment of the doctor as to whether the patient is entitled to charity or part charity which is contemplated should be paramount in the decision, and that both hospital and profession should recognize his right to make an adverse de-

cision. Again we call attention to the fact that his own judgment may be quite as erring as that of the social worker—sometimes more so, and that it is his duty tho go over all the data pertaining to the patient's finances before passing hasty judgment.

In social investigations of this kind we believe it is a sound principle that the family unit should be taken as a basis for estimating the finances of the patient, and that a minimum family budget of expenses should be computed for the particular community or communities from which the hospital draws its material.

In the computation will enter the total earnings of the family, the number of children who are dependent, the state of employment or unemployment, the indebtedness of the family as a whole, previous illness and expense, the effect that the particular illness may have upon the family income, the nature of the disease, and the amount of money that it would require both to meet the medical expense and a possibly increased family expense. The character of the patient is no small item. His responsibility and the ability to manage his expenditures is one of the variables which must be reckoned with. The personal judgment of the social worker must frequently be called upon in making her final decision.

The larger the hospital, the more elaborate must necessarily be the organization devoted to social investigation, and the less will personal knowledge of patients be possible. We believe that every community hospital should have some methodical way of making such investigations. For the largest hospitals and those who can adopt it without unreasonable burden, we suggest the plan that we gave in detail in last year's report, in connection with Harper Hospital. In the medium sized hospitals—say of approximately 50 to 75 beds, the employment of a smaller number of workers, and perhaps a less elaborate system, would be merely common sense. For the medium sized hospital we suggest the following plan:

Requirements—A social worker on full or part time. Often a volunteer from one of the guilds or local charitable societies may well do. Record blanks; a place for making investigations, and for filing records.

Data to be Obtained—Name; address; record number; date; members in family; their sex, date and place of birth; time in the United States; time in city; occupation, school grade; weekly wages of family members and their health; others in household to be cared for; doctor referring case; chief complaint; medical diagnosis and prognosis; social diagnosis; employers; family physician; possible sources of pay outside family, i. e., relatives, friends, churches, lodges, etc., their relationship to patients and their addresses; debts of family, for what, original amount, amount paid and balance due; income per month—from wages, from lodges, from benefits and compensations, from property rentals and from other sources; expenditures per month—rent or house contract, food, clothing, heat and light, other needs; equity in real property, value of the same; value of property owned outright.

For the smallest hospitals (say of 25 beds), a personal knowledge of the patient obtained from the hospital or doctor will usually be paramount in the investigation. We believe, however, that all of the main data should be reduced to writing. The value of such records is very great from many standpoints.

Requirements—A superintendent who may devote the required time to the investigation. Record blanks (cards) and a simple filing system.

Upon such blanks or cards may be recorded the following data:

Name; address; date; occupation and that of supporting members of the family; number of dependents; state of employment or unemployment; debts or other obligations; previous illness; medical diagnosis and prognosis; name of family or referring physician; available income per month; expenditures per month, including rent, food, clothing, heat and light, etc., value of real estate; remarks.

PART II

THE UNIVERSITY HOSPITAL

In its report to you last year, your Committee gave you data bearing directly or indirectly upon the charity work of that institution. The statistics given were largely those of a period from May 1, 1926, to February 1, 1927—nine months in all, and were furnished us by Dr. Harley A. Haynes, Director of the University Hospital. We have recently received from him a statistical report based upon the experienceof twenty-six months, from May 1, 1926, to July 1, 1928, and covering what are to us the more important items given in last year's report. The general averages are about the same, the distribution ratio of patients over the various groups being within a fraction of one per cent. There

has been a very slight decrease of the relative proportion of "pay patients" (i. e. —those who pay their hospital expenses), particularly those entering without the direction of outside physicians. The only class showing any increase at all is the emergency group (VIII), which increased approximately one per cent of the total admissions from January, 1927, to June, 1928. The geographical distribution remains practically the same. To refresh your memory and bring a few important statistics up to date, the following tables are presented. They deal with the number of patients admitted to the hospital in the eight different groups.

*Total hospital registrations, 26 months	60,803
Average per year	28,063
Total admissions to hospital in 26 months	38,582
Average admissions per year	17,807

* Patients applying to the hospital are first "registered", if found eligible. Only a part of these are actually admitted and assigned beds.

GROUP I.

"State Patients: Those patients hospitalized by the Probate Court under Public Acts 267 of 1915, or 274 of 1913." (see last year's report).

Total 26 months	20,645
Average per year	9,533

GROUP II.

"County Patients: Those patients who are sent by the Superintendent of the Poor and whose hospital expenses are guaranteed by the County in which the patient resides."

Total 26 months	898
Average per year	414

GROUP III.

"Students in attendance at the University of Michigan or the Michigan State Normal College at Ypsilanti."

Total 26 months	534
Average yer year	246

GROUP IV.

"Persons bringing letters from their regular Medical Attendants, recommending their admission." (Patients in Group 6 not included).

Total 26 months	4,218
Average per year	1,947

GROUP V.

"Persons who can truthfully sign an affidavit that they are unable to pay the usual minimum fee charged by the Medical Profession outside the hospital."

Total 26 months	7,325
Average per year	3,381

GROUP VI.

"Patients who are able to pay, in addition to their hospital charges, fees for Professional services, and are admitted to the services of Medicine, Surgery or X-ray."

Total 26 months	1,488
Average per year	684

GROUP VII.

"Doctors and the families of doctors, nurses, hospital staff and employes."

Total 26 months	1,506
Average per year	695

GROUP VIII.

"Emergency Patients: Patients entering the hospital voluntarily without medical refer or public guarantee. This includes emergencies and 'guests' indicating relatives admitted with patient, and charged according to service rendered—i. e., room and meals, etc."

Emergencies, 26 months	1,901
Guests, 26 months	58
	1,959
Average per year, emergencies	877
Average per year, guests	27
	904

Your Committee has added considerably to its funds of information this year, and has had several important conferences, including one with Dr. Clarence C. Little, President of the University, and Dr. Hugh Cabot, Dean of the Medical School. It acknowledges with gratitude its debt to Dr. Harley A. Haynes, Director of the Hospital, who has been ever ready to give information and has devoted much time and interest to our purpose.

Before giving you the final results of its study during the past two years, and making the recommendations which are suggested by it, your Committee thinks it well to define, as it sees it, the position of the medical profession of the state in the matter before us, and thus perhaps make clearer the reasons for making this investigation.

STATE MEDICINE*

The practice of medicine may be properly defined as the application of scientific

* The American Medical Association has declared its opposition to State Medicine in the adoption of the supplementary report of the Reference Committee on Legislation and Public Relations, St. Louis session of the House of Delegates, 1922. Journal of the A. M. A., Vol. 78, p. 1715.

"The American Medical Association hereby declares its opposition to all forms of 'state medicine' because of the ultimate harm that would come thereby to the public weal through such form of medical practice. 'State medicine' is hereby defined for the purpose of this resolution to be any form of medical treatment provided, conducted, controlled or subsidized by the Federal or any state government or municipality, excepting such service as is provided by the Army, Navy or Public Health Service, and that which is necessary for the control of communicable diseases, the treatment of the indigent sick, and such other services as may be approved by and administered are not disapproved by the state medical society of which it is a component part."

facts to the prevention, the cure or the alleviation of disease. When the commonwealth, through its appointed agents, undertakes this duty, we have "state medicine" in its broadest sense. Physicians, however, as a rule, use the term with a more restricted meaning, and speak of such practice as that in which the commonwealth undertakes those duties that have been performed by a group of private individuals who have been educated in our universities and colleges and duly qualified and registered as physicians. The profession of Michigan recognizes that it is purely within the province of the state to do the work now being done by our Public Health Department in the way of disease prevention and public education. Such is not only necessary for the public weal, but an inestimable aid to physicians in their daily work. It recognizes too that the wards of the state that are in public institutions, such as asylums and prisons, must be under state control and cared for by physicians employed by the state. Again it recognizes the employment of city and county physicians and the care of the poor as a necessary and legitimate function of the community. It heartily approves of the idea that the state and its various counties, from purely humanitarian motives and for economy, should undertake the care of its indigent sick and disabled, in order that suffering may be relieved and that they may be restored to a state of social independence. The items of practice enumerated above are purely of public concern and should be sharply distinguished from the personal medical care accorded to the self respecting, economically independent citizen.

We are in the midst of profound social changes and we are wondering what place the physician of the future will hold in the scheme which is now unfolding. We are looking with a concern, perhaps not fully unjustified, to the many encroachments which are being made upon private practice. Among other things, the uncertainty as to what part the commonwealth is to play in medicine is causing us some apprehension. Here in Michigan, at the present moment and in this inquiry, we are particularly concerned in regard to practice at the University Hospital.

Is the socialization of medicine to develop here as it has in some European countries? Is the practice of medicine to be brought gradually under direct state administration? To be sure, there is much to hinder progress in this direction. We are in an era of great prosperity in which our people are not only able to pay for the necessities of life, including medical service, but for many luxuries as well. The average American desires to be independent and to pay his way. Undoubtedly there will always be a demand for the personal services of the private physician because of the obvious personal interest and attention which he is able to devote to his patients, but we fear and we believe with some justification that conditions of practice may be made so difficult that the private physician, and consequently the community that he now serves, may suffer severely.

President Coolidge has recently sounded a vigorous warning against paternalism. When a man has devoted his life to the problems of government, and knows its strength and weakness, we can well afford to respect his opinion. He is seeing the necessity of stressing the dangers of such interferences and of substituting governmental for private enterprise. America has attained its industrial leadership because private initiative has been untrammeled. Europe, under paternalistic principles, has been slipping backward. Medicine in Europe, once individualistic, but today confronted by the inroads of state control, is rapidly losing its leadership to young America. We believe that the personal practice of medicine is safer in the hands of the private physician than in those of the state. Under private management we have seen a slow, steady improvement in the standards of practice and the medical care that has been extended to the people of America. Perfection will never be attained, but we believe that, in the main, progress is satisfactory. America is pre-eminently a land of opportunity and with this idea prevailing, every man is stimulated to give the best of himself, and this applies to the physician as well as to others, for he naturally is only human. The problems of private practice are very often extremely difficult, requiring devotion to the patient's interests, concentration, most careful discriminations, and often much time and patience for their solution. They require frequently a knowledge of the private affairs of the patient and his most intimate confidences, that only a physician, who is at the same time a friend, can have. It requires often too great sacrifices of personal convenience on the part of the physician. We believe that only under private control can these things be adequately met, and that otherwise society would suffer.

The physician is interested in his means

of livelihood. He would scarcely be a good citizen or a good physician if it were otherwise. The advance of medical science has called for an ever increasing expenditure for labor, equipment, transportation, medical litertature, attendance on medical meetings and a thousand and one incidentals. These things take a substantial portion of his gross income. The cost of living has increased. The hours are long and the labor strenuous, and must be compensated for by more recreation and vacations if he is to maintain his health. And lastly, insurance against misfortune and old age must be provided for. Competition is keen, the income is irregular and usually ceases when, for any reason, the doctor is not at work. His financial responsibilities are probably no greater than those of many a business man, but nevertheless they call for a great deal of consideration and a protection of his pocketbook, and this constitutes one reason why he is opposed to "state medicine". It is an axiom that no business or profession can succeed in giving satisfactory service unless the financial returns are in keeping with that service. We believe we have a right to ask that the commonwealth which has educated us and has charged us with the responsibility of caring for the sick throughout the state should hesitate to make our burdens heavier.

THE UNIVERSITY AND ITS MEDICAL SCHOOL

The State Medical Society and its individual members take pride in the University and the position which it occupies among the great institutions of learning. It is *our* University and we owe to it our allegiance. We, of course, thoroughly approve of its objects, for education is one of the great fundamentals upon which the life of the nation and the welfare of its people depend. We are particularly interested in the Medical School and the Hospital, not only because they are integral parts of the University, but because they represent to us that branch of science to which we have devoted our lives.

Both the Medical School and the Hospital are under the President and the Board of Regents of the University. They are closely allied in their activities and separated only for purposes of administration. The Board of Regents is a constitutional elective body and has full power and authority in directing the policies of the University. It is necessary to have this background in discussing the matter at hand.

Your Committee believes that the medical profession of the state fully realizes the importance of the work which the Medical School is doing in preparing students for practice and what it means to the people of our state. The better the preparation of those students, the better will be the service which they afterwards render. We realize that an ample and varied clinical material is necessary in the teaching of undergraduates.

TEACHING MATERIAL

The Hospital is now receiving patients at the rate of 28,063 a year, of whom 17,807 are admitted and assigned beds and 10,254 remain as out-patients. There are approximately 190 students in the junior class and 150 in the senior; a total of 340, for whom provision for teaching material must be made. Members of the clinical staffs use this same material and no further consideration of their needs in this respect, we are told, is necessary. The teaching requirements center in the student. All of the 28,063 are available for study and instruction—at least there is no rule which forbids it. The distribution of material is naturally uneven for the various departments — for example, oto-laryngology would seem to have an over abundance and obstetrics too little, though special effort is made to obtain such patients. The variety necessary to illustrate pathological conditions which the students should be shown seems very satisfactory.

Your Committee has been able to obtain no very satisfactory answers to the question as to whether the amount of clinical material was satisfactory or not—it might well be so because of its necessarily unequal distribution and the different opinions of the heads of departments as to what constitutes such. We have been impressed with the fact that, in some departments at least, the care of such a great volume of patients is a decided tax upon the time and energies of the teaching staff. The administration itself of a department in which there are a large number of patients must be a burden of no little moment. We have a feeling, though it is not a conviction, that fewer patients in some of the departments would serve the purposes of the medical school rather better. Considering the total number registered, it is apparent that the material is not altogether economically used. Patients in Groups III, VI, and VII, (total 1625 a year), are used but little, and the 10,254 a year registered, but not admitted, are also in considerable part unused. Were the demand for a larger amount of material a

pressing one, a more deliberate effort to utilize these patients for teaching would, it seems to us, have been in evidence.

ADMISSIONS

Bearing in mind the attitude of the medical profession toward "State Medicine", its real interest in our University and its Medical School and Hospital, and with great appreciation of their needs and the difficulties with which they have to contend, we approach the matter of admissions which is the main issue in our inquiry.

It is, it seems to us, essential that the whole procedure of admissions be reviewed and that then the patients be considered in groups and analyzed as such, for they vary greatly in kind and the problems presented are widely different.

All patients applying at the hospital are first registered, if considered eligible. An attendant at the desk obtains the usual data of name, age, social status, etc. Inquiry is made as to income, number of dependents, and in a general way an attempt is made to classify them as to their ability to pay. Only such as are considered to be in the "A" class (see below) are accepted, duly registered and admitted as out-patients, except that patients for the medical, surgical and X-ray departments are received, whatever their circumstances. Also, no inquiry as to ability to pay is made in the case of those provided for by the state and counties—such inquiry is made by the Probate Court which issues the order. Patients in Group VII would also be an obvious exception and patients in Group VIII are accepted without formality and investigation as to finances made afterwards. Patients in Group III are paid for out of funds provided by the University Health service and are admitted without reference to circumstances.

The desk attendant is, and must be, a person especially fitted for the work and who has some training in social investigations of this kind. If hospitalization is recommended, the patient is referred to the credit department, where a detailed financial inquiry is made to check the information previously given and to obtain information as to their financial responsibility. "Pay patients" make a deposit to cover probable hospital expenses.

Patients of the "A" class, admitted to the departments of surgery, medicine or X-ray, are again questioned when in the course of the examination it is thought they might well pay small fees for professional service.

There is, as pointed out last year, a social service department at the hospital. Contrary to our impression at that time, this department is used almost solely to inquire into the family and social status of those to whom it is thought such service and advice would be useful. In such examinations the finances are, of course, considered in detail, and this information is made use of in checking data previously given. If marked discrepancies are found, the patient is refused admission thereafter.

FINANCIAL RATING OF PATIENTS

"A"	yearly income from	0 to $1,800	for single	persons
"B"	yearly income from	$1,800.00 to 3,000	for single	persons
"C"	yearly income from	3,000.00 to 5,000	for single	persons
"D"	yearly income from	5,000.00 and over	for single	persons
"A"	yearly income from	0 to 2,500	for married	persons
"B"	yearly income from	2,500.00 to 5,000	for married	persons
"C"	yearly income from	5,000.00 to 10,000	for married	persons
"D"	yearly income from	10,000.00 and over	for married	persons

These are merely general guides, influenced by the number of dependents and the length of illness and also whether this illness has affected the family income. It is extremely difficult to set down any rigid rules covering such a classification, and the hospital has to depend very largely upon the judgment of those in charge of classifying. A great deal of literature has been published regarding budgets for individuals and families under varying circumstances, and there seems to be considerable variance of opinion, even among those who have given this field of study great attention. It is the policy of the hospital to have those who are classifying these patients acquainted with the social research in this field.

OUT-PATIENT DEPARTMENT

There are at the present time approximately 10,000 patients who register at the hospital, receive out-patient's care, but are not admitted to the institution and assigned beds. They constitute the out-patient department. They all pay a registration fee of $2.00 (out of state patients $3.00), and except for routine urine and blood examinations, they pay for laboratory and X-ray, but not for professional services if they are regarded as unable to pay for them. Even the poorest, however, pay 50 cents for each refer and a moderate professional fee is charged to a patient if it is thought he is able to meet it. B, C and D patients registering, but not admitted to the hospital, pay much higher rates for "extras" and professional fees in accordance with the service rendered and their ability to pay. An inquiry into the eligibility of out-patients is made at the time of registration, but with the large

number which apply, only a more or less superficial investigation has seemed possible. There can be no question whatsoever that many patients who would be paying a private physician for his services are registered and receive service for fees comparable with those of the outside profession. This service is similar to that of physicians in the surrounding communities who are in position to provide comparable attendance. At the present time, rather inadequate service is rendered these patients as compared with the high standards which obtain when the patient is actually admitted to the hospital. The clinic, in its operation, resembles that of many another large hospital, or the office of a too busy, overworked practitioner. A very decided effort is being made at the present time toward its betterment. Patients in this group are of comparatively little value for instructing students. It would seem that fewer patients, more leisurely and studiously worked up, would better serve the patient and the cause of teaching. Their eligibility is being more carefully scrutinized than ever before, but still leaves much to be desired. Your Committee is of the opinion that only such patients should be admitted to this service as are unable to pay a private physician; patients, in other words, whose meagre financial resources are such as to preclude their going to a doctor and paying him even a moderate fee. Your Committee commends the effort that is being made to be more strict, and suggests efforts in this direction should be made to a point where only strictly eligible patients are admitted. The use of information obtained from experts in social investigation would seem to be indispensable.

It would seem that a Social Investigation Department of a high order might be formed to supervise admissions in the out- and in-patient departments. The hospital has had practical experience in the matter and because of a university association they would be able to appreciate and employ persons of a superior intellectual character to organize and administer the department in an orderly, intelligent and just manner.

PATIENTS ADMITTED TO HOSPITAL

GROUP I.

These patients are admitted from the various counties under direction of their Probate Courts.

The largest single group (average 9533 a year). These patients, under certain restrictions prescribed by law, are entitled to University Hospital care. As pointed out last year, they constitute the "poor" of the state in its real sense, and your Committee is thoroughly in accord with the idea of their admission. It is for the state and counties on the one hand, and the University Hospital on the other, to settle questions as to this service. The counties are mainly interested in seeing that these patients have good medical and surgical attendance at a reasonable cost. The University is interested in giving them the best of hospital and professional care and also in their use as clinical material. There has been some complaint that at times they are kept in the hospital longer than is necessary, and Public Acts 1927, No. 317, to amend Act 267 of 1915 was passed to meet this contingency. It calls for a monthly report to the probate court which issues the order, stating the condition of the patient, the expense incurred, and limiting the financial liability of the county to six months, without a new order. It has been suggested that it would be an economy to the county if some of the patients were sent home for follow-up care when the Probate Court was in position to provide such. It might relieve hospital congestion, be more pleasing to patients, and encourage the Probate Courts to use the University Hospital with greater freedom. Proper adjustments of these and other difficulties that may arise would help to maintain this service as the principal source of teaching material.

As to possible abuse of this privilege by patients, it is obvious that there are but few patients able to pay for such medical service, who are willingly recipients of public charity. We believe that our Judges of Probate Courts, as a rule, constitute a very efficient barrier against abuses, though some reports to the contrary have come to us. In some instances, patients even pay the county small sums toward their care, which shows a commendable discrimination, for of course there are all degrees of poverty.

This group and Group II are, and may well be, the chief reliance of the medical school for purposes of instructing students. They are given a certain preference in admission, and are skillfully and humanely cared for. This, of course, we commend most highly. No investigation is made of their finances by the hospital in respect to their eligibility as court cases, nor would this seem necessary.

GROUP II.

County Patients: "Those patients who

are sent by the superintendent of the poor and whose hospital expenses are guaranteed by the county in which the patient resides." (Average 414 a year).

Our experience with county superintendents of the poor leads us to believe that elligibility for medical and surgical service is guarded with scrupulous care and that these patients are entitled to all they obtain.

GROUP III.

Students in attendance at the University of Michigan or the Michigan State Normal College of Ypsilanti. (Average 246 a year).

A small group. Your Committee has made no attempt to investigate this service more than to learn that its problems are large and complex. Should a study seem desirable, it should, we believe, be taken up by others, and we leave it as it is without comment.

GROUP IV.

"Persons bringing letters from their regular medical attendant, recommending their admission." (Patients in Group VI not included). Average 1947 a year. A large, and to us, very important group.

This is the first of the groups of so-called "pay-patients" on our list. As with Group V, they pay their hospital expenses, but not professional charges, except that in the "full time" departments small fees are required if it is thought they are able to meet them. Practically from the beginning of the University Hospital, say 50 years ago, it has been the custom for physicians to send patients there for care. This has been a benefit to patients, a distinct advantage to the individual doctor, and has supplied a considerable amount of teaching material for the medical school. It has been of special value to patients and physicians living in counties of the state not well supplied with facilities for diagnosis and treatment, a condition which still exists, although not to the same degree as formerly. The habit of sending patients to Ann Arbor is not easily modified. Many medical men regard it as a right rather than a privilege, and are reluctant to relinquish it. It forms today perhaps the principal connection between the Medical School and the profession of the state. The former has cherished this affiliation, not only because it has furnished material, but because it has helped to meet its responsibility to the physician after graduation, and has laid a foundation for enlarging its scope in this direction. If the patients sent and received were strictly unable to pay more than their hospital expenses, your Committee would have no comment to make except to endorse the practice. It is perfectly apparent, however, that in the past there have been many abuses. The Hospital has shown a most commendable effort to limit them, and such patients are investigated with increasing care as to their finances. It is evident that striving in this direction must, and we learn does, meet with considerable unpleasantness. It is well to point out that the hospital here is dealing with individual doctors and not with the profession as a whole. Your Committee believes that the medical men of the state, as a body, will heartily endorse every effort on the part of the hospital to limit this service to those who are really unable to pay the doctor at home, or elsewhere, for the particular service which is contemplated. We have no desire to limit the number of patients in this group. Quite the contrary. We believe that its numbers will be increased if the profession, as a whole, feel that their admission and those of Group V are being more and more strictly guarded and that losses of income from this source are being gradually reduced.

GROUP V.

"Patients who can truthfully sign an affidavit that they are unable to pay the usual minimum fee charged by the medical profession outside the Hospital." (Average 3381 a year).

A very large group, nearly double the size of the previous one, similar in many respects to it and constituting with it nearly 19 per cent of total admissions. The two groups together provide at present the best teaching material that the medical school possesses, since these patients, as a whole, represent less advanced pathological conditions and rathe r greater intelligence than those of Groups I and II. The two together constitute under the present "self-supporting" plan of financing (see last year's report) an indispensable source of income to the Hospital.

It has long been the custom of the Hospital to receive patients of the "A" class who would sign an affidavit to the effect that they are unable to pay the minimum fees of outside physicians. In previous years there can be no doubt that many did so who might well pay at least a moderate professional fee in addition to the hospital charges. There has been, and is now,

a real effort being made to scan the finances of these prospective patients and to refuse their admission if it is thought they are not worthy of this charity. Your Committee realizes the difficulty in bringing about such a change. It requires a gradual shift of viewpoint on the part of all those who are concerned in their admission, a quiet determination and a persistent, but discriminating effort to carry out the program. Those really entitled to admission must not be eliminated. The Hospital must be commended for its efforts in this direction. People all over the state have grown to regard the University Hospital service as their prerogative rather than a privilege entirely within the discretion and control of the Hospital. It is primarily a teaching institution and as a matter of fact, the people have no more right to demand admission to it for their private and personal medical care than they have to call upon the State Legal Department for professional services in connection with their private legal problems, or to use public grounds and buildings for their personal projects. There are several deterrents, however, preventing too great abuses—a hesitation about submitting to the delays, lack of privacy, and inconveniences of such a great public institution, a desire to employ their private physician and a hesitation about being used for clinical teaching. These are by no means powerful enough, however, to prevent many from obtaining skillful service at a low cost if they can do so. They may easily be persuaded that they are fully entitled to it. Some are of European origin, where such service is often regarded as a legitimate right. It is not American. With the asumption of American opportunities and far greater emoluments from their work, they should also assume American responsibilities.

In the last analysis, the responsibility in admission of patients to this group and Group IV rests with the President of the University and the Board of Regents. They might be helped to a satisfactory solution of the problem if a greater insistence were made on reference from practitioners of regular medicine. The use of data obtained from expert social workers would, it seems to us, be an absolute essential.

There are a number of interests particularly to be considered in this and Group IV—the people from the standpoint of broad benevolence and social economy—the University from the teaching standpoint—the hospital and its desire to render good service to patients, and to satisfy its sometimes conflicting elements, and a self-respecting, upstanding profession anxious to fulfill its obligations to the public and to protect its own integrity. We must not expect things impossible of perfect adjustment, nor be too impatient if betterment comes by degrees and not in a day.

GROUP VI.

"Patients who are able to pay, in addition to their hospital charges, fees for professional services, and are admitted to the services of medicine, surgery or X-ray." (Average, 684 a year).

A group rather recently added (about seven years ago); not large, but one involving some very important questions.

The teaching policies of our American medical schools are being constantly and seriously discussed and are ever in a state of unrest and experiment, with always a striving for better medical instruction. Among other things, there has been the question of "full time" professorships, and it apparently remains unsettled, though showing signs of an early passing. We are concerned only with this practice as it affects our own University. It was adopted by the Board of Regents as a measure worthy of trial for the departments enumerated above. There were difficulties in the way of the medical school or hospital assuming the considerable extra burden made necessary by the increased salaries of all giving full time service, and as an expedient the plan was adopted to receive patients who were frankly able to pay for professional attendance and to charge them a commensurate fee, the same being regulated, as with private physicians, by their ability to pay. The greater part of the sum thus obtained is applied to the purpose of meeting the required extra salaries of physicians in the departments mentioned, and, as pointed out last year, a part of the salary of a needed assistant in Neurology. We find that the budget of 1928-9, for the salaries of clinical teachers to be paid by the medical school, is $184,040, and by the Hospital $60,850. Practically 25 per cent of the total amount devoted to all of such professional salaries is derived from private patients. The comparative isolation of this group in private rooms makes their general use as clinical material somewhat difficult. They are under the supervision of the various staffs and internes exactly as all other groups, and are available for teaching purposes. The extent to which these patients are used for student teaching is dependent

upon the interest which their cases present and is entirely controlled by those in charge. As a matter of fact, as pointed out last year, their value as clinical material is negligible. The main reason for accepting them is plainly one of income. The argument that has been advanced that they provide a certain cultural atmosphere for men about to enter practice, and that the outstanding men of the faculty who are giving "full time" derive satisfaction from their contact, seems to us of little importance in weighing evidence for and against this practice. One other argument for it seems worthy of mention—namely, that if these men now on "full time" were to be placed on "part time," allowing them to conduct a private practice, they would be in direct and able competition with the rest of the profession. Medical men outside accept competition from their fellows as a matter of course, and are undoubtedly stimulated to better effort thereby. The life of every man and his period of activity is limited. He must struggle like others to acquire a foothold and to maintain it, and the force of his competition is limited, and this is true whether he be connected with an institution like the University or not. The "part time" men at Ann Arbor who are thus in competition with us offer us no particular concern. On the other hand, great pleasure and benefit has resulted from the association with men who have at once combined the dual function of teacher and practitioner. The matter puts on an entirely different aspect in the case of a state institution that is conducting a private practice.

The essential things in the head of a clinical department are that he should be able to give personal instruction himself, and to instill into his students and staff a keen scientific interest in the work and a kindly human attitude toward patients; also to administer his department in an orderly manner and to lead the way in scientific investigation for those who are of an inquiring turn of mind. It seems to us essential that a teacher should have had, and usually should maintain, contact with patients in actual private practice. The last cannot find its best expression in the "full time" plan. Experience seems to demonstrate that the question of "full time" is not the essential element—it is the individual. It has not worked out satisfactorily at Ann Arbor, and many of those who were in favor of it before its adoption are now lukewarm or opposed to it at least in its present form.

If the plan, or any modification of it, is to be continued, we at least believe that it should not be supported on the present basis. This is "State Medicine" for the sake of education, but nevertheless "State Medicine," and there seems to be no sufficient reason for it.

If the University Medical School and Hospital, to which we look for the highest standards, not only in scientific medicine, but as well in medical social ethics, are receptive to such practice, into what depths of unsoundness may not the rest of us be induced to dip? We suggest that very serious consideration be given to the question of this practice, and that it be annulled, if not at once, at least gradually.

GROUP VII.

"Doctors and members of their families, nurses, hospital staff and employes." (Average, 695 a year).

This group calls for but little comment. Professional courtesy dictates that physicians and their immediate dependents receive the service of other physicians without charge—there is no conflict with the interests of the outside medical men. They pay their hospital expenses and are thus no burden to it.

Nurses, hospital staff and employes are treated here as in all hospitals—a custom showing a fine professional spirit.

GROUP VIII.

"Emergency patients." (Average, 877 a year).

Patients entering the hospital voluntarily, without medical reference or public guarantee. A group concerning which we have but little to add to what was said last year. Patients in acute distress and danger that come to the door of any hospital must, as a matter of ordinary benevolence, be received and cared for. The automobile accounts perhaps for the small increase in the figures of this year over those of last.

CONCLUSION

In presenting its report of last year the committee believes it has helped to clear away much misinformation in regard to the University Hospital and has succeeded in creating a greater sympathy with its purposes. It hopes that this report will be still more helpful in attaining these objects and in furthering that friendly spirit of co-operation so essential to the best interests of medical school, hospital and private physicians in the pursuit of their common aims.

We are looking forward to that time when the University Medical School will not only be sending out into the state well fitted young men to practice, as at present, but will be taking a large and important part in the post-graduate instruction of him who is now serving the public in a most important capacity, so that throughout his life of practice he will be kept in constant touch with its educational advantages. What is already being done in this direction we welcome most heartily.

Respectfully submitted,

R. R. Smith, *Chairman,*
J. Walter Vaughan,
W. H. Marshall.

Report adopted and recommendations concurred in by the House of Delegates, September 26, 1928.

F. C. Warnshuis, *Secretary.*